DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/01/2011 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER LAKEVIEW MANOR INC SUMMARY STATEMENT OF DEPTICIENCIES SEACHWAY DRIVE NO INTERPRETATION SES, CITY, STATE_UP CODE 45 SEACHWAY DRIVE NO INTERPRETATION SES, CITY, STATE_UP CODE 45 SEACHWAY DRIVE NO INTERPRETATION SHOULD BE PROVIDED PALAN OF CORRECTION ASSOCIATION SHOULD BE PROVIDED PALAN OF CORRECTION SHOULD BE PROVI	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155077		` '	(X2) M A. BUII		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER LAKEVIEW MANOR INC STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DRIVE PREFIX TAC SUMMARY STATEMENT OF DEFICIENCES [EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USE DENTIFYING INFORMATION) (F 000) INITIAL COMMENTS This visit was for a Post Survey Revisit [PSR] to the Investigation of Complaint IN00091856 completed on 06/14/2011. Complaint IN00091856 corrected. This visit was in conjunction with the Investigation of Complaint IN00092458. Survey dates: July 20 & 21, 2011 Facility number: 000032 Provider number: 105077 AIM number: 100273330 Survey Team: Joyce Hofmann, RN Census bed type: SNF: 22 SNF/RN: 126 Total: 148 Census payor type: Medicare: 24 Medicare: 24 Medicare: 24 Medicare: 24 Medicare: 24 Medicare: 24 Medicare: 102 Other: 22 Total: 148 Sample: 6 Lakeview Manor, Inc. was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 162 in regard to the PSR to the Investigation of Complaint RN Quality review completed 7/22/11 Cathy Emswiller RN			B. WING			R-C 07/21/2011		
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Cathy Emswiller RN		compliance with 42 C 410 IAC 16.2 in regar	FR Part 483, Subpart B and rd to the PSR to the					
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		Cathy Emswiller RN						

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155077	B. WING		R-C 07/21/2011		
NAME OF PR	0112	1/2011					
LAKEVIEV	V MANOR INC		45 BEACHWAY DRIVE INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	TIVE ACTION SHOULD BE CED TO THE APPROPRIATE		